AVENUE U PODIATRY, P.C
FAMILY FOOT CARE

Dr.Charles G.Marchese, F.A.C.F.A.S, F.A.P.W.H

PATIENT'S INFORMATION

Date : _____ **Your email address :** _____

Name : _____ _____ **Gender :** _____

Adress : _____ _____ _____ _____

Street APT# City/ State Zip Code

Home phone Number : _____ **Cell # :** _____

Date of Birth : _____ **Social Security :** _____

How did you hear of our office? ☐ Internet ☐ Friends/Family ☐ Physician Referral ☐ Other

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Employer : _____ **Work # :** _____

Spouse's Name : _____ **In case of emergency:** _____

Primary Insurance company : _____ **ID # :** _____

Subscriber : ☐ Self ☐ Other (If other please complete following information)

Subscriber Name : _____ **Relationship :** _____

Employment : _____ **SOC.SEC :** _____ **D.O.B:** _____

Secondary Insurance company : _____ **ID # :** _____

Subscriber : ☐ Self ☐ Other (If other please complete following information)

Subscriber Name : _____ **Relationship :** _____

Employment : _____ **SOC.SEC :** _____ **D.O.B :** _____

Name of medical doctor or primary care-physician : _____ _____

First Last

Address : _____ **Phone Number :** _____

Reason for Consultation : _____

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Please check any of the following that pertains to you :

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Bronchitis
- ☐ Diabetes
  - ☐ Insulin Dependent
  - ☐ Non-Insulin Dependent
- ☐ Thyroid
- ☐ Epilepsy
- ☐ Heart diesease
- ☐ High blood pressure
- ☐ Hepatitis/Liver Disease
- ☐ Mental/Nervous Disorder
- ☐ Depression
- ☐ Glaucoma/Cataracts
- ☐ Visual Disturbances
- ☐ Phlebitis
- ☐ Varicose Veins
- ☐ Poor Circulations
- ☐ Headaches/Dizziness
- ☐ Rash/Itching
- ☐ Nausea/Vomiting
- ☐ Ulcer/Indigestion
- ☐ Weight Changes
- ☐ Bowel Complaints
- ☐ Swelling/Edema
- ☐ Nail Changes
- ☐ Numbness/Tingling
- ☐ Accident/Trauma
- ☐ Rheumatics Fever
- ☐ Renal Disease
- ☐ Medication Allergies — Please List

PATIENT'S INFORMATION

1. We accept all insurance when we can. Co-payment, Co-Insurance, deductibles and out of network claims are non-covered services and are your responsibility. You will be billed for these at the time of service or days there after. Payment is excepted promplty.

2. **Managed Care Plans:**
   Obtaining referrals and approvals for treatment is the patient's responsibility. All the procedures being performed must be specified on the referral. Otherwise treatment cannot be rendered. As a courtesy we can HOLD a personal check for 5 business days, in the amount of the procedure being performed. When you have obtained the refferal/authorization we will kindly return the check to you. The alternative is to re-schedule the procedure, and we will fax to your primary care physician in order to obtain the referral specifyng the procedure to be performed.
   You will be billed in full for any claims denied to no referral/authorization

3. **Out of Network:**
   If you choose to see us an out-of-network provider you are subject to a deductible with your insurance carrier that is you responsibility at the time of service, you will be billed by special arrangements only. Should collection become an issue, we do use an outside collection company who will add a reasonable and/or attorney fee to your outstanding balance.

4. **Medicare:**
   All ; deductibles and 20 % Co-Insurance are your responsibility.

Patient's Signature : **Date:**

FINANCIAL POLICY

I request that payment of authorized Medicare benefits be made on my behalf to Avenuw U Podiatry, P.C/Dr.Charles G.Marchese, F.A.C.F.A.S, F.A.P.W.H and/or Associates for any service(s) furnished to me. I authorize any holder of medical information about me to release to the ealth Care Financing Adminstration and its agents any information needed to determine these benefits ot the benefits payable to related services.

I hereby authorize th processing of my medical insurance either by eletronic or manual method by the listed provider.
My signature authorizes payment of all major medical and/or surfical benefirs to whcih I am entitled for the listed ensurer below to pay the listed provider assignee. I further authorize the assignee to release all medical and/or insurance claim information necessary to secure the payment(s).
I recognize my financial obligation of any co-insurance, co-pay, deductible and non-covered services that may be required. This agreement will remain in effect untill reviked by me in writing. A copy of this documnet is considered as valid as an orginal.

Patient's Signature : **Date:**

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Patient's Name :

Medication Allergies :

MEDICATION LOG

Date	Medication	MG	Direction

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PATIENT CONSENT FORM

The Departure of Health and Human Services has established a "Privacy Rule" to help insure that peronal health care ifonmation in protected fro privacy. The Privacy Rule was also created in order to provide a standar for certain health care providers to obltain their patients' consent for ises and disclosures of health information about the patient to carru our treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropiate and necessary , we provide informaton and information about treatment, payment or health-care operations, in ored to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, paymnet, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consemt to the use or disclosure of your personal health infromation, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future tume you may request to refuse all or part of you PHI. You may not revikve actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak witho our HIPAA complaince officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice..

Print Name: _____ **Signature:** **Date:** _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PARENTS

To our Valued patients:

The name of Personal Health Information (PHI) has been identified as a national problem causing patients inconvinience, aggravation and money. We want you to know that all of our employee, managers and doctors continually underges training so that they may understand adn comply with government rules and regulations regarding th Health Insurance Portibility and Accountability ACT (HIPAA) with particual emphasis on the "Privcy Rule". We stive to achieve the very highest standars of ethics and intergrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI .

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of perforation if they feel that an event in any way compromises our policy of intergrity. More ao, we welcome you input regarding any service problem so that we may remedy the situation promptly

Thankyou for being one of our highly valued patients.